WHITE PAPER

QUALITY ASSURANCE
DELIVERABLE #3

OCCUPATIONAL HEALTH SERVICES PILOT PROJECT

DRAFT, October 18, 2000

Introduction

The white papers on enhancing occupational health expertise and service and care coordination evaluated the current occupational medicine practice behaviors of Washington physicians and the effectiveness of the service and care coordination environment in which the physicians operate. The first white paper suggested options to improve Washington physician practice behaviors so that they more closely followed that of physicians in the best occupational medicine programs nationally. The second white paper outlined the design of a state-of-the-art occupational medicine delivery system, coordinated by the envisioned Centers of Occupational Health and Education (COHE).

This white paper evaluates Washington's workers' compensation quality assurance program to understand how it attempts to insure competent physician performance. The paper presents new research examining the impact of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) on the occupational medicine practice behaviors of Washington physicians and evaluates the potential role of the Joint Commission in quality assurance. Further research examines the opinions of Washington employers concerning their perspective on important occupational medicine quality measures.

This paper describes a central role for the COHE in the quality assurance process and provides a draft quality improvement plan to help guide the COHE in that role.

Purpose

This white paper identifies, evaluates and prioritizes options for providing quality assurance in the pilot Centers of Occupational Health and Education (COHE) and by the pilot physicians.

The recommendations in this white paper are based on:

- Survey results from a random sample of 186 physicians who treat injured workers in Washington regarding their experience with quality assurance.

- Survey results from twenty-three occupational medicine programs from throughout the United States that were identified as providing excellent occupational medical care.

- Survey results from a random sample of 201 Washington employers regarding their views on important quality indicators for occupational medicine.

- An analysis of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and its quality assurance activities with occupational medicine practices.

- Statistical analysis examining the extent to which variables traditionally associated with quality care predict utilization of best practice behaviors by physicians.

- Focus groups with claims adjudicators and occupational nurse consultants in L&I to determine indicators of quality performance.

- Interviews with the Nursing Supervisor of L&I's Occupational Nurse Consultants and other occupational nurse consultants.

- Review of the scientific literature regarding physician practice performance standards.

- Review of scientific literature regarding existing quality of care guidelines and their use in the occupational medicine setting.

- Review of results from L&I's previous managed care study.

- Review of the Attending Doctor's Handbook and Chiropractic Physician Guide.

- Review of the Medical Aid Rules and Fee Schedules.

What is the current state in Washington?

The Department of Labor & Industries (L&I) acts as a trustee of the medical aid fund and, as such, has a duty to ensure that medical care is good quality and is delivered promptly, efficiently and economically. L&I uses many means to achieve this, such as education, utilization management, research, quality assurance, and others. This paper discusses three quality assurance

techniques used in Washington: physician credentialing and approval, advisory committees and physician sanctions.

Physician credentialing and approval: To treat injured workers in Washington, a healthcare provider must qualify as an "approved provider" under L&I's rules.[1] The provider must complete an application, provide copies of current licensure and medical specialty board certification, and meet all applicable state and/or federal licensing requirements.[2] If the department approves the health care provider's application, it issues a provider number, which allows the provider to receive payment for services. In treating and billing for services for an injured worker, the provider agrees to accept L&I's rules, maintain documentation for a minimum of five years to justify the services provided, and furnish these records and supportive material to the department upon request.

Although this application process validates credentials and licensure and establishes certain rules for provider behavior, its requirements are not sufficiently stringent to require the type of occupational medicine practice behaviors discussed in Deliverable #1, nor is there analysis of the providers own quality assurance efforts, if any. Assessments of that sort, although important, are beyond the scope of L&I's credentialing and approval process.

Advisory committees: The *Medical Aid Rules* integrate L&I's quality assurance program with the quality improvement efforts of the state's medical association by charging two provider advisory committees with some of the responsibility for monitoring care delivery:

- A chiropractic advisory and utilization review committee, appointed by the Director, advises L&I on policy affecting chiropractic care, quality assurance, clinical management of cases, utilization review and the establishment of rules.

- The Medical Advisory Industrial Insurance Committee, appointed by the Washington State Medical Association advises L&I on policies affecting medical care and rehabilitation, quality control and supervision of medical care and the establishment of rules and regulations. It also helps resolve controversies between the L&I and medical care providers, handles questions of medical ethics, and advises the department on medical education.

Although originally intended to review individual cases and providers, these committees, in practice, have evolved in a more general advisory capacity, in part due to liability concerns.[3] [4]

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[1] *Attending Doctor's Handbook*, Washington State Department of Labor & Industries 1999, p. 79-81
[2] Certain specialties such as Pain Clinics and Head Injury Programs must be CARF accredited
[3] WAC 296-20-0100
[4] WAC 296-20-01001

Provider Sanctions: After a provider is approved, L&I can deny, revoke, suspend, limit or impose conditions on a health care providers' authorization to treat under the Industrial Insurance Act; such action, in practice, is difficult to take. L&I conducts quality assurance reviews to determine compliance with rules and regulations of the department. A health care provider can lose his or her authorization to treat for a variety of reasons, including, among others, incompetence, unreasonable refusal to comply with the recommendations of a board-certified specialist, repeated use of experimental, hazardous or contraindicated treatment, or failure to comply with the department's rules. [5]

Although it is possible for the department to terminate provider eligibility 60 days after written notice of the proposed termination, a provider has several levels of appeal regarding a department action or sanction, culminating in an appeal to the Superior Court. This can be very a time consuming process, taking many years to resolve. Meanwhile, during the appeals process, the provider can continue to treat injured workers unless his or her license to practice medicine has been revoked. The department has a process in place to work with a provider through education and peer dialogue that is used to try and correct problems prior to resorting to this legal process.

The impact of outside review agencies

The extent of evaluation of providers required by Washington's quality assurance program is less than would be undertaken to meet the standards of an outside review agency, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Since 1951, the JCAHO has developed state-of-the-art, professionally-based standards and evaluated the compliance of health care organizations against these benchmarks. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care, evaluating and accrediting nearly 20,000 health care organizations and programs in the United States.[6] The Joint Commission established the Ambulatory Health Care accreditation program in 1975 to encourage quality patient care in all types of freestanding ambulatory care facilities. The JCAHO accredits more than 1,000 ambulatory care organizations. This includes occupational health programs, ambulatory surgery centers, group medical practices, rehabilitation centers and chronic pain programs.

Research for this white paper compared the frequency of JCAHO evaluation of medical providers in Washington with model occupational medicine programs. There is a significant difference:[7] 78% of national model practices

[5] Reasons for doing so are listed in WAC 296-20-015

[6] The Joint Commission on Accreditation of Healthcare Organizations website at: http://www.jcaho.org/trkhco_frm.html

[7] Chi-Square: DF=1 Value = 19.715 p-value <.001

undergo Joint Commission scrutiny compared to only 30% of Washington providers.

Given this difference in JCAHO review rates, research for this white paper further assessed JCAHO accreditation to determine whether it helped to differentiate between the number of best practice behaviors Washington physicians employed. The white paper for enhancing occupational health expertise identified seven practice behaviors associated with the nation's best occupational medicine practices:

1. Notification of the employer of worker injury.
2. Use of treatment protocols and guidelines.
3. Use of standardized work restrictions.
4. Ability to identify job (ergonomic) risks.
5. Ability to perform case management.
6. Specification of work restrictions rather than removal from work when an injured employee is unable to perform his or her regular job.
7. Use of specialized occupational medicine information systems.

The Washington physicians studied, on average, have three of these seven behaviors in their practices.[8]

Using statistical analysis, we assessed whether three factors theoretically likely to impact best practice behaviors (percent of practice devoted to occupational medicine, a physician board certified in occupational medicine as the practice director, and involvement of the JCAHO in practice accreditation) actually had an impact in Washington. The research found:

- Percent of practice devoted to occupational medicine and involvement of the JCAHO in practice accreditation produced significant differentiation between providers.

- A physician board certified in occupational medicine directing the practice did not differentiate between providers.[9]

The higher proportion of best practice behaviors in physicians whose organizations undergo Joint Commission accreditation may result from the organization's efforts to meet JCAHO's standards. These standards address a health care organization's actual level of performance in specific areas relating to care of individuals and the management of health care organizations. The standards aim to improve outcomes; they place little emphasis on *how* to achieve these objectives. Standards are generally

[8] N = 186 Mean = 2.98387 Median = 3.00

[9] Regression analysis: Adjusted R-square= 0.2563, $p < .001$ Independent Variables: JCAHO (coeff = 0.811, p =.004), % Program devoted to Occupational Medicine (coeff = 0.0267, $p < .001$), and board-certified occupational medicine director (coeff = .8113, p = .207)

updated every two years. [Appendix A discusses these processes in greater detail.]

What performance indicators are important to employers and workers in Washington?

One focus of the Joint Commission is the measurement of quality indicators that measure processes important to consumers of healthcare services. Table 1 displays a list of quality indicators important to Washington employers.[10]

Table 1: Washington Employers' Attitudes about Quality Indicators

Indicator	Considered Very Important
Speed in returning to work	86%
Reducing absenteeism	82%
Minimizing re-injury rates	81%
Clarity and accuracy of medical documentation	80%
Coordinate employee early return to work	79%
Employee satisfaction with treatment	77%
Amount of medical expenses	76%
Timely referrals to specialists	69%
Investigate cause of injury	68%
Providers speed in completing reports	68%
Ability to communicate with medical provider	55%
Days on light duty	53%
Waiting time in medical providers office	51%
Specialty of medical provider	46%
Provider involvement in finding alternate work	38%
Medical provider recommended workplace improvements	35%

As part of this project, the University of Washington research team conducted a worker satisfaction survey. The results of this survey demonstrate the quality indicators that are important to injured workers.[11] Many of these variables mirror those shown to be important to employers in table 1. The list (see below) will be revised with further research by the University of Washington.

Variables of worker satisfaction

- Satisfaction with overall quality of care
- Satisfaction with coordination of care among providers

[10] Washington State Department of Labor and Industries Employer survey, The Gilmore Research Group, Seattle, Washington, August 2000

[11] See Deliverable 7G: Satisfaction among Injured Workers with Health Care Delivery: Final Survey Results, University of Washington Department of Environmental Health

- Rating of overall experience with health care
- Length of time to obtain initial care
- Rating of timing of referral for workers referred to specialists
- Satisfaction with the quality of care provided by specialists
- Length of time to return to work
- Communication between doctor and worker regarding worker's job and return to work
- Communication between the doctor and employer regarding return to work and job modification
- Satisfaction with job modification arrangements
- Self-reported recovery status

Similar worker studies have not been completed, but the employer findings are similar to other studies.[12] As the envisioned Centers for Occupational Health and Education develop quality assurance programs, these top-rated indicators provide direction for the processes that need to be tracked. They highlight the importance of alternative duty programs, elimination of work hazards, and improved communication – all features of the COHE's care coordination program.

What is the future desired state?

Washington currently has in place a comprehensive workers' compensation quality assurance mechanism that effectively integrates activities of L&I with major professional review committees in the State. Despite these efforts, a significant gap exists between the occupational medicine practice behaviors of Washington physicians and those of physicians practicing in the best occupational medicine programs nationally. The proposed role of the Centers of Occupational Health and Education as care coordinator will provide new opportunities to measure, track, and improve quality. Linking quality indicators to incentives can help close the physician expertise gap and provide care which more closely meets the quality needs of Washington workers and employers.

What is the best way to achieve the desired state?

Integrating L&I's current quality assurance system with complimentary activities from the proposed Centers of Occupational Health and Education should help ensure that the new, community-based, pilot occupational medicine delivery system provides high quality medical care that should reduce the likelihood of long term disability in Washington's injured workers.

Here are the steps in developing this quality assurance system:

[12] "Measuring Managed Care Performance", *The Journal of Workers Compensation*, Fall 1999

A. Develop supplementary requirements for attending physicians seeking to become pilot project physicians. These would be in addition to the current requirements for providing care in the workers' compensation system.

The pilot attending physicians are a key component of the occupational medicine delivery system that is comprised of medical providers, the COHE, and the L&I staff. These physicians must practice at a higher level if this new occupational medicine delivery system is to have a significant impact on the reduction of long term disability following worker injury.

Here are some key expectations that should be added to the physician application supplement:

1. The pilot physicians should agree to adopt the following behaviors:

- Prompt appointments for workers with on the job injuries.
- Routine employer notification after injury.
- Provision of a standardized work restriction form.
- Same day notification to L&I and the COHE of new worker injuries.
- Ability to provide, or referral for, workplace evaluation in the case of injuries caused by ergonomic hazards.
- Use of appropriate best-practice strategies such as care protocols, maps, guidelines, etc.

2. The pilot providers should agree to develop electronic communication in their practices that:

- Enables the digital transmission of first injury reports to L&I and the COHE.
- Allows encrypted, e-mail communication with L&I and the COHE.

[The importance of medical information becoming digital in the provider office or COHE will be discussed further in the white papers on information processes.]

B. Require that the COHE have an effective comprehensive quality assurance program with strong medical leadership to evaluate and improve care delivered by the COHE and the pilot physicians. [Appendix B describes a comprehensive Quality Assurance Program for the COHE.] [13]

[13] In 1998, the American Medical Association identified this as the quality continuum: clinical practice guidelines, performance measurement and process and outcome analysis. It is agreed that there are variables over which the physician does not have control, but utilizing the tools of guidelines and case management physicians can integrate clinical care. See Kagel, L ,"AMA Clinical Quality Improvement Forum Ties It All Together", *Journal On Quality Improvement*,1999 Feb .24(2)

1. The COHE should be Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) accredited either as an ambulatory care provider or as part of a larger healthcare organization. This will require that the COHE adopt a comprehensive quality assurance structure and undergo meaningful on-site inspections.

2. The COHE should have a medical director who is competent in occupational medicine and a recognized leader in the local medical community and experienced in quality assurance activities.

3. The COHE should have a formal Quality Assurance Committee that evaluates the processes of the COHE. This committee should have the capacity to expand to include the pilot project attending physicians.

4. The COHE should have a peer review mechanism for medical care delivered by the pilot physicians.

5. The COHE should have a stakeholder advisory committee. There is further detail about this committee in draft bylaws developed for the COHE. The COHE needs to understand the perspectives and needs of other providers, employers, L&I, and injured workers.[14]

C. Require that the COHE develop or adopt a series of quality indicators that measure general processes involving communication and safe return to work and integrate those indicators with the more specific, diagnosis-related quality indicators for work-related carpal tunnel syndrome, low back pain and fractures currently under development in Washington.

1. At the outset, the COHE should select processes and quality indicators that measure injured worker satisfaction and the ability of the COHE and pilot physicians to improve performance and the five areas outlined in Table 1. As noted above, these areas involve transitional work programs, elimination of work hazards, and improved communication – all features of the COHE's care coordination program.

2. Because the COHE should be responsible for raising the level of occupational medicine practiced in its local community, it should select processes and indicators that not only measure the performance of the COHE but also of the aggregate performance of pilot providers affiliated with the COHE.

[14] University of Washington, Department of Health Services, *Workers Compensation/Occupational Health National Trends Study, June 1997*

Appendix A

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Measurement of Medical Performance in Occupational Medicine

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) considers the following factors when measuring medical performance:[15] [16]

- The patient care is efficacious and appropriate.
- The service is available in a timely manner, effective, continuous with other care and care providers, safe, efficient, and caring and respectful of the patient.
- The degree to which an organization does the right thing well is influenced by the design of its functions.
- The effect of an organization's performance of these functions is reflected in patient outcomes and in the cost of its service.
- Patients and others judge the quality of healthcare based on patient health outcomes.

Monitoring performance requires the systematic collection of data designed to evaluate the service provided. Data collection focuses on processes and outcomes, particularly those that serve as good markers for the quality of patient care.

Data analysis uses statistical techniques to determine the significance of observations made in order to determine appropriate areas for improvement. It is important to observe data over time to identify whether processes are improving. Occasionally, external benchmarks are available for comparison.

Key steps of quality assurance in an occupational health clinic, include:

- The clinic leadership reviews the services provided to identify areas of concern.
- The clinic leadership appoints a team to develop the quality assurance plan. Clinic staff who perform key functions are members of the team.

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[15] 2000-2001 standards for Ambulatory Care, Joint Commission on Accreditation of Healthcare Organizations, 2000

[16] For further information on process improvement, see Ryder, R. and W. Newkirk "Integrating Continuous Quality Improvement into Occupational Health Programs" in *Occupational Health Services: Practical Strategies for Improving Quality and Controlling Costs* (Chicago: American Hospital Publishing, 1993) p. 13-26.

- The quality assurance plan serves as a guideline for the team in evaluating clinic functions.

- The team identifies and measures quality indicators for significant clinic processes and outcomes. Initial measurements serve as a baseline and, when such data is available, can be compared to external standards.

- The team evaluates processes identifying areas for improvement and implements process changes.

- On-going measurement of quality indicators establishes whether the process changes cause improvements in quality.

- A calendar is developed which outlines the processes to occur during given periods. The processes include data collection, data evaluation and recommendation, reporting and follow-up as indicated.

Appendix B

Draft Elements of the Quality Improvement Plan for The Centers for Occupational Health and Education

Purpose

This quality improvement plan identifies how the Center for Occupational Health and Education's (COHE) quality improvement activities might be prioritized, reviewed, monitored and communicated.

Policy

The COHE quality improvement program should measure the quality, availability, and the effectiveness of medical care provided to injured workers by the COHE and pilot attending physicians in an effort to improve the processes that affect care delivery. The program will include:

- Credentialing and contracting with providers according to the accepted criteria of the COHE, L&I and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

- Developing quality control reports on all equipment used to provide patient care in the COHE.

- Establishing a Quality Improvement Council with representatives of all disciplines providing care in the COHE that will set performance indicators and assign responsibility for reviewing designated areas of responsibility. The Medical Director of the Center shall assume the chairmanship of the Quality Council. The Department Directors will be responsible for reviewing and reporting the assigned indicators.

- Reporting the conclusions of the Quality Improvement Plan to appropriate members of the Business and Labor Advisory Committee and the Department of Labor and Industries.

Procedure

The COHE will follow the following procedures:

Upon accepting a provider application supplement, credentialing will assure competency of the provider to care for patients in the Center. Copies of the credentialing application and all certificates and licenses will be maintained by the Department of Labor and Industries.

On an annual basis in December of each year, members of the council, with input from staff, and L&I will select performance indicators of care to be monitored in the following year. These indicators should include the various functions of care i.e. Assessment and Treatment of Patients, Patient Education, Continuity of Care and Patient Satisfaction. High volume or high-risk procedures will be reviewed for inclusion in the plan. Sentinel Events, should they occur, will have a review initiated immediately upon reporting of the event. Indicators will be included that monitor results of the educational efforts for community providers credentialed by the Center.

Staff at the department/pilot service area level will be aware of and participate in all Quality Improvement activities in their area. The Quality Assurance Council will review the findings, make recommendations as indicated and communicate to the various department managers. The Council will meet at least bimonthly to oversee these activities.

Each department/service area will report on their activities quarterly during assigned months.

Adverse occurrences or sentinel event investigations involving the Center of Health and Education service area will be reviewed as they occur and monthly until resolution. The COHE will perform a root cause analysis for all sentinel events. Changes as a result of these investigations will be communicated to the staff through departmental/service area staff meetings.

The Director of each service will be responsible to communicate Quality Assurance activities to the staff in writing.

The COHE Medical Director will be responsible to report pre and post education findings to the community providers based on L&I reports.

Annually the Quality Assurance Council will review the findings for the year and determine:

1. Indicators that have shown substantial improvement and no longer need to be reviewed.

2. Indicators that have shown improvement in care but still need to be monitored

3. New indicators to be monitored based on the findings of the current year's quality improvement activities.

4. Educational activities to recommend for the following year based on findings reported.

The Quality Assurance Council will write an annual report to summarize the findings and activities of the council for the year. The council will present the findings to the committee that oversees the Center of Occupational Health and Education.

Performance Improvement Program
Indicator Development Methodology Sheet

Employer Notification

Indicator Statement	Providers will notify employers when treating an injured worker within twenty-four hours of the appointment
Rationale	Employers want to be informed of injured worker status
Function	Care of the patient
Dimension of Performance	Safety and efficiency of the outcome of care
Methodology	Concurrent
Time Period	First and Second Quarter
Indicator Type	Rate-based
Data Source	Medical Record
Data Calculation	Numerator: cases meeting criteria Denominator: reliable sample of the new injured workers seen in a month
Threshold for evaluation (TFE)	98%
Reference for TFE	OHR survey results - 2000
Data Collector	Medical Assistant
Data Analyst	Administrative Director, Medical Director
Evaluation	Report variances not meeting threshold to Quality Assurance Council with recommendations for improvement

Performance Improvement Program
Indicator Development Methodology Sheet

Provision of Work Restrictions Form

Indicator Statement	Each injured worker is given a completed work restriction form on discharge from each visit that outlines the physical capabilities of the injured worker.
Rationale	Employers must be informed of the physical capabilities of the injured worker if they are to function safely in the workplace.
Function	Safety of the patient
Dimension of Performance	Safety and efficiency of the outcome of care
Methodology	Concurrent
Time Period	First and Second Quarter
Indicator Type	Rate-based
Data Source	Work Restriction Form
Data Calculation	Numerator: cases meeting criteria Denominator: reliable sample of workers treated during the month
Threshold for evaluation (TFE)	98%
Reference for TFE	OHR survey results - 2000
Data Collector	Discharge clerk or medical records clerk
Data Analyst	Administrative Director, Medical Director
Evaluation	Report variances not meeting threshold to Quality Assurance Council with recommendations for improvement

Performance Improvement Program
Indicator Development Methodology Sheet

Use of Treatment Guidelines

Indicator Statement	Injured workers are treated according to accepted clinical guidelines.
Rationale	Medical research demonstrates that injured workers treated according to accepted treatment guidelines have decreased disability and fewer lost days from work.
Function	Care of the patient
Dimension of Performance	Effectiveness of care
Methodology	Retrospective
Time Period	Fourth Quarter
Indicator Type	Process
Data Source	Medical Record
Data Calculation	Numerator: cases meeting criteria Denominator: reliable sample of workers treated during the month. (At least 30.)
Threshold for evaluation (TFE)	85%
Reference for TFE	OHR survey results – 2000; ACOEM Guidelines
Data Collector	Occupational health nurse
Data Analyst	Medical Director
Evaluation	Report variances not meeting threshold to Quality Assurance Council with recommendations for improvement

Performance Improvement Program
Indicator Development Methodology Sheet

Ergonomic Work Site Evaluation

Indicator Statement	Employers whose workers are injured by ergonomic hazards are offered an ergonomic work site evaluation.
Rationale	Injured workers who have been injured from ergonomic hazards will have a delayed recovery and possible re-injury if the ergonomic hazard remains in place.
Function	Care of the patient
Dimension of Performance	Effectiveness of care
Methodology	Retrospective
Time Period	Fourth Quarter
Indicator Type	Process
Data Source	Medical Record
Data Calculation	Numerator: cases meeting criteria Denominator: reasonable sample of designated injured workers.
Threshold for evaluation (TFE)	95%
Reference for TFE	OHR survey results – 2000
Data Collector	Occupational health nurse
Data Analyst	Medical Director
Evaluation	Report variances not meeting threshold to Quality Assurance Council with recommendations for improvement

Performance Improvement Program
Indicator Development Methodology Sheet

Prompt Appointments for Medical Treatment

Indicator Statement	All injured workers will be given an appointment to be seen within twenty-four hours of seeking an appointment unless triaged and referred to a higher level of service.
Rationale	Early access to care for an injured worker will lessen disability and reduce lost time from work.
Function	Assessment of patients
Dimension of Performance	Access to care
Methodology	Concurrent
Time Period	First and Second Quarters
Indicator Type	Process
Data Source	Appointment Schedule
Data Calculation	Numerator: cases meeting criteria Denominator: reasonable sample of initial injured worker visits.
Threshold for evaluation (TFE)	95%
Reference for TFE	Estimate of excellent performance level.
Data Collector	Receptionist/clerk
Data Analyst	Administrative Director, Medical Director
Evaluation	Report variances not meeting threshold to Quality Assurance Council with recommendations for improvement

Performance Improvement Program
Indicator Development Methodology Sheet

Worker Satisfaction with Treatment

Indicator Statement	Injured workers will report satisfaction with the medical treatment received.
Rationale	Injured workersents should be satisfied with the care they receive.
Function	Improving organizational performance
Dimension of Performance	Respect and care of the patient
Methodology	Retrospective
Time Period	Third Quarter
Indicator Type	Rate-based
Data Source	University of Washington Workers Satisfaction Survey Program
Data Calculation	Numerator: cases meeting criteria Denominator: reasonable sample of injured workers treated
Threshold for evaluation (TFE)	94%
Reference for TFE	Occupational Health Research Patient Satisfaction Survey
Data Collector	Designated clerical staff
Data Analyst	Administrative Director, Medical Director
Evaluation	All results reported to Quality Assurance Council

Performance Improvement Program
Indicator Development Methodology Sheet

Employer Satisfaction

Indicator Statement	Employers will be satisfied with the medical care provided to their employees.
Rationale	The COHE must meet the needs of the employers.
Function	Improving organizational performance
Dimension of Performance	Safety of the patient
Methodology	Retrospective
Time Period	Fourth quarter
Indicator Type	Rate-based
Data Source	University of Washington Employer Satisfaction Survey
Data Calculation	Numerator: cases meeting criteria Denominator: reasonable sample of employers who have employees treated for injuries
Threshold for evaluation (TFE)	92%
Reference for TFE	Occupational Health Research Employer Satisfaction Survey Program
Data Collector	Designated clerical staff
Data Analyst	Administrative Director
Evaluation	All results reported to Quality Assurance Council

Performance Improvement Program
Indicator Development Methodology Sheet

Sentinel Events

Indicator Statement	Any sentinel event reported will have a Root Cause Analysis performed.
Rationale	Any unexpected occurrence that involves death or serious physical or psychological injury or the risk thereof, following treatment will be followed up immediately.
Function	Continuity of care
Dimension of Performance	Safety of the patient
Methodology	Concurrent
Time Period	Continuous
Indicator Type	Sentinel
Data Source	Any
Data Calculation	All
Threshold for evaluation (TFE)	All
Reference for TFE	JCAHO
Data Collector	Medical Director, Administrative Director
Data Analyst	Medical Director, Administrative Director
Evaluation	All reported to Quality Improvement Council

Performance Improvement Program
Indicator Development Methodology Sheet

Accurate Billing

Indicator Statement	Billing for services rendered in the Center for Occupational Health and Education will be accurate.
Rationale	Bills should accurately reflect the services provided.
Function	Leadership
Dimension of Performance	Appropriateness
Methodology	Concurrent
Time Period	Third Quarter
Indicator Type	Process
Data Source	Invoices
Data Calculation	Numerator: invoices meeting criteria Denominator: reasonable sample of invoices sent during period
Threshold for evaluation (TFE)	98%
Reference for TFE	Expected accuracy
Data Collector	L&I staff
Data Analyst	L&I staff, Billing staff, Administrative Director
Evaluation	All results reported to Quality Assurance Council

Quality Assurance Calendar												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Equipment Calibration/Check												
PFT												
Breath Alcohol: • Calibration records • Equipment check • Manufacturer check (2/yr)												
Audiometer (Yearly)												
Fire Extinguishers: • Monthly (Center Staff) • Yearly (Vendor)												
Certificate of Registration:												
• CLIA												
• DEA												
Preventive Maintenance:												
• Height / Weight Scales												
All Electrical Equipment: • Clinical equipment–Inspected and tagged by Clinical Engineering • Non-Clinical equipment by vendor/staff												
Environment of Care:												
• Fire Drills (quarterly)												
• Disaster Drills (1/yr)												
Environment of Care (continued): • Safety Assessment of site (2/yr)												

Quality Assurance Calendar												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
• Security Self-Assessment of Site (1/yr)												
• Safety/Workplace Violence Survey of physicians and staff (1/yr)												
X-Ray:												
• Radiologist film quality evaluation												
• Yearly check on lead aprons												
• Radiology techs badge check												
• Processor maintenance												
• State license and inspection												
Customer Satisfaction:												
• Staff training												

Mandatory Continuing Education	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Life Safety/Fire Safety: • CPR • Hazcom/MSDS/Universal Precautions • Emergency procedures/review disasters • Medical equipment safety • Security • Violence in the workplace • Proficiency check occupational health skills												

Performance Improvement Calendar												
Performance Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Notify employer within 24 hours of injured worker visit.	X	X	X	X	X	X						
Work restrictions are given at each visit.	X	X	X	X	X	X						
Injured workers are treated using clinical guidelines.										X	X	X
Employers offered ergonomic hazard evaluation							X	X	X			
Injured workers are seen within 24 hours of seeking an appointment.	X	X	X									
Patients will be satisfied with care.						X	X	X		X	X	X
Employers will be satisfied with the care their employees receive.						X	X	X				
Sentinel Events will be reviewed.	X	X	X	X	X	X	X	X	X	X	X	X
Billing will accurately reflect the care given.							X	X	X			

Indicators on a Dashboard					
Indicator	Benchmark / Target	Current Qtr.	Previous Qtr.	Previous Qtr.	Previous Qtr.
Employer Notification					
Work Restrictions					
Treatment Guidelines					
Worksite Evaluations					
Access to Care					
Patient Satisfaction					
Employer Satisfaction					
Accurate Billing					

Sample Policy

Customer Satisfaction and Service Quality

Purpose

To ensure that the satisfaction of our patients, client companies, and other payer sources directing patients to occupational medicine are equally influential in determining the quality of care we deliver. Customer satisfaction will be regularly monitored, reviewed, and incorporated into Process Improvement plans for on-going improvement.

Policy

The goal of the Center of Occupational Health and Education is to delight all of our customers. We will place unparalleled focus on meeting or exceeding their needs, while respecting patients' and employers' rights, the American College of Occupational and Environmental Medicine (ACOEM) Code of Ethical Conduct, and any applicable federal and state rules or regulations.

I. Customer Service and Client Satisfaction

- All complaints are acknowledged upon receipt and followed up with findings or resolutions. These findings are communicated to the complaining party and, where applicable, to the employer, prospective employer, or payer source/authorized agent.
- Comments, complaints, and suggestions are routinely evaluated and incorporated, as needed, into new policies, procedures, or solutions. Location- or department-specific process improvements may also be identified through these vehicles.
- Customer satisfaction is consistently monitored through patient questionnaires, tracking and trending of complaints, and personal observations of all staff members.
- The Center for Occupational Health and Education staff are trained to be alert and aware of patient dissatisfaction. They will monitor patient satisfaction through personal observations, and take immediate and appropriate action to resolve issues.
- The two primary customers of occupational medicine, patients and client companies, are regularly given the opportunity to provide feedback.

II. Patient Feedback

- Patient satisfaction cards are available to all patients, at all locations.

- Patient satisfaction statistical survey reports are completed quarterly by the administrative office, reviewed by appropriate personnel, and discussed and shared with staff.
- Patient satisfaction survey findings are reviewed with the governing body or senior administration, as appropriate.
- Patient satisfaction findings are incorporated into the service quality and quality improvement program through review of the finding or trends by the administrative office, medical leadership, or other personnel.

III. Employer Feedback

- Employers are regularly reminded of the Center of Occupational Health and Education's commitment to client satisfaction, and are advised how and where issues or complaints should be directed through newsletter articles or special mailings.
- All complaints and/or suggestions are directed to the Center.
- Requests for information are directed to the account executive responsible for the account.
- Center-, location-, or department-specific process improvements are identified, improved, and measured, as needed, for increased satisfaction and problem resolution.
- Employers are formally surveyed once a year. Results are tabulated and reported to internal and external customers. Results or findings are incorporated into the service quality and process improvement programs through review of the finding or trends by the administrative office, site supervision, medical leadership, or other personnel.